Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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REFER TO CHANGE REQUESTS 1650 & 1846

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CLARIFICATION/MANUALIZATION--*EFFECTIVE DATE: Not Applicable*
IMPLEMENTATION DATE: Not Applicable

This instruction manualizes carrier claims processing instructions contained in Program Memoranda) AB-02-052 (CR 1650) and AB-01-125 (CR 1846) regarding the processing of telehealth services.

Section 4159, Telehealth Claims, is added to manualize carrier claims processing instructions and coding requirements for covered telehealth services.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

1. Where the patient has exhausted home health benefits,

2. Where the HHA could not respond on a timely basis, or

3. Where the physician could not have foreseen that intermittent services would be needed, e.g., and more services are necessary.

In the postpayment review described below, be alert to any trends that show a pattern of using one reason consistently to justify the use of homebound services.

With respect to the appropriateness of homebound injections and venipuncture services under § 2051 in areas where HHAs furnish services, process homebound claims from physicians/clinics as other claims for services incident to a physician's service using the reasonable charge procedure described in § 5203 for each type of service. Each calendar quarter review the records of homebound services for all physicians/clinics who bill for homebound services in areas where home health services are available.

The quarterly postpayment review must identify any physician/clinic who may be abusing the use of homebound services when HHA services are available. Where an investigation shows that a physician/clinic is seemingly operating in direct competition with already existing and available suppliers of the same services, make an educational contact with the physician/clinic to inform them that where the patient is eligible for home health visits and the particular services can be furnished by the HHA, homebound services by the physician/clinic are not covered (except when reasons such as described above are present). If a second quarterly review shows no change, the subsequent claims from the physician/clinic must be given a special prepayment review to insure that the billings are proper. Also, apply regular utilization review guidelines to all homebound services, including EKG's billed by physicians/clinics whether or not home health services were available in the particular area. Use these guidelines to assure that the services are not excessive, that they are covered, and that the charges (including mileage) are appropriate. (See §§ 2051 and 5203.)

4149. SURGERY - MULTIPLE PROCEDURES PERFORMED DURING THE SAME OPERATION

Establish guidelines for use in coding charges for surgery when more than one surgical procedure is performed during the same operation, through the same opening, through a different opening or by different surgical procedures. The guidelines should establish the allowable amount based upon (l) the major procedure only, or (2) the major procedure plus partial amounts for other procedures.

4151. SERVICES PERFORMED BY MORE THAN ONE PHYSICIAN FOR THE SAME SURGERY.

Where claims are received from a surgeon, assistant surgeon, an anesthesiologist, or any other physician for services performed in connection with the same procedure, establish the necessary controls to insure that these claims are associated and correctly coded. In this way, you can avoid making incorrect payments resulting from inconsistent coding of unassociated claims.

Obtain from the appropriate Part A Intermediary a list of all approved teaching programs at hospitals in the service area. Use this information to identify and deny claims for assistant surgeons where the hospital has an approved teaching program in the appropriate specialty. However, allow claims where there are exceptional circumstances, such as the operating surgeon's not being involved with the hospital's teaching program or never using resident assistants or your awareness of circumstances at the hospital which would lead to the presumption that a resident was unavailable. Document and review such circumstances (See §5038ff.)

If payment is to be made for non-resident assistance at surgery follow the guidelines in §5039.

4152. CLAIMS FOR COCHLEAR IMPLANTS AND DEFIBRILLATORS

Charges for cochlear implant and defibrillator devices are included in the hospital's PPS payment even though the speech processor may not be received until several days after discharge from the hospital.

Deny charges for any defibrillatory or cochlear implant devices or services in support of surgery. These charges are also included in the hospital's PPS payment. The physician's surgery charges remain payable. Also, if the physician establishes that a replacement was implanted in the physician's office, pay that claim. We do not, at the time, know if these charges are being billed to you under local codes as part of the physician's charges, or, in the case of defibrillatory lead implants and replacements, under HCPCS Code A4557. There are no CPT or national HCPCS codes for speech processors. In any event, do not pay such claims if you receive them.

4159. TELEHEALTH SERVICES

See §15516 for coverage and payment rules pertaining to Medicare telehealth services.

Submission of telehealth claims for distant site practitioners.--Claims for professional consultations, office visits, individual psychotherapy, and pharmacologic management provided via a telecommunications system are submitted to the carrier that processes claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate CPT procedure code for covered professional telehealth services along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished.

To claim the facility payment, physicians/practitioners will bill HCPCS code "Q3014, telehealth originating site facility fee"; short description "telehealth facility fee." The type of service for the telehealth originating site facility fee is "9, other items and services." For carrier processed claims, the "office" place of service (code 11) is the only payable setting for code Q3014. There is no participation payment differential for code Q3014 and it is not priced off of the Medicare Physician Fee Schedule Database file. Deductible and coinsurance rules apply to Q3014. By submitting HCPCS code "Q3014", the biller certifies that the originating site is located in either a rural HPSA or a non-MSA county.

Physicians and practitioners at the distant site bill their local Medicare carrier for covered telehealth services, for example, "99245 GT". Physicians' and practitioners' offices serving as a telehealth originating site bill their local Medicare carrier for the originating site facility fee.

Exception for store and forward (non-interactive) telehealth.—In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. Covered store and forward telehealth services are billed with the "GQ" modifier, "via asynchronous telecommunications system." By using the "GQ" modifier, the distant site physician/practitioner certifies that the asynchronous medical file was collected and transmitted to them at their distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

Carrier editing of telehealth claims.— Effective October 1, 2001, covered telehealth services include CPT codes 99241 – 99275, 99201 – 99215, 90804 - 90809, and 90862. When furnished as telehealth services these codes are billed with either the "GT" or "GQ" modifier.

Approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. Carriers must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare. Install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

If you receive claims for professional telehealth services coded with the "GQ" modifier (representing "via asynchronous telecommunications system"), approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. You may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.

If you deny telehealth services because the physician or practitioner may not bill for them, use MSN message 21.18: "This item or service is not covered when performed or ordered by this practitioner." Use remittance advice message 52 when denying the claim based upon MSN message 21.18.

If a service is billed with one of the telehealth modifiers and the procedure code is not designated as a covered telehealth service, deny the service using MSN message 94: "This item or service was denied because information required to make payment was incorrect." The remittance advice message depends on what is incorrect, e.g., B18 if procedure code or modifier is incorrect, 125 for submission billing errors, 4-12 for difference inconsistencies. Use B18 as the explanation for the denial of the claim.

4160. CLAIMS FOR OUTPATIENT PHYSICAL THERAPY SERVICES FURNISHED BY CLINIC PROVIDERS.

The coverage of outpatient physical therapy permits payment for outpatient physical therapy services furnished an eligible Part B enrollee by any participating provider of services. For purpose of this provision, "provider of services" includes hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, public health agencies, and clinics certified to participate in the program. A physician-directed clinic that bills for services furnished incident to a physician's services, and sends the bills to you for review and payment on a reasonable charge basis may, under this provision, become a participating provider of a outpatient physical therapy services. See §§2200ff. for information as to the coverage of outpatient physical therapy services, including physician's certification and plan of treatment requirements. The instructions in this section cover the procedures for reviewing bills for outpatient physical therapy services and for paying the provider for the reasonable cost of such services when the provider is a clinic.

The clinic uses the HCFA-1490 to bill outpatient physical therapy to the Part B carrier. Payments are made subject to the usual Part B deductible and coinsurance.

4160.1 Computation of Payment by the Clinic.--A separate HCFA-1490 will be filed for services furnished on a cost basis, i.e., outpatient physical therapy services other than physician's services. This is to facilitate carrier and provider recordkeeping. In order to simplify the payment computation for outpatient physical therapy services, use a payment rate of l00 percent of charges where the clinic agrees. Payment, of course, is based on 80 percent of the charges (or estimated cost, see following paragraph) after deducting the unmet Part B deductible. Adjust any underpayment or overpayment in the final cost settlement. This final settlement is made as follows: The total Part B costs are reduced by the total deductibles applied to all billings. The result is multiplied by 80 percent. The total payment amounts to the clinic and patient are then deducted.

Where the costs and charges are significantly different, reduce or increase the interim payment rate to estimated cost. However, the patient's liability is based on charges and remains the same regardless of any adjustment in the cost payment rate.